2002

The Charter and Health Care: Guaranteeing Timely Access to Health Care for Canadians

Patrick Monahan
Osgoode Hall Law School of York University

Stanley H. Hartt

C.D. Howe Institute
125 Adelaide Street East
Toronto, Ontario
M5C 1L7

Canadian Publication Mail Sales
Product Agreement #1605933

C.D. Howe Institute
Commentary

www.cdhowe.org No. 164, May 2002

The Health Papers

The Charter and Health Care

Guaranteeing Timely Access to Health Care for Canadians

Stanley H. Hartt Q.C.
Patrick J. Monahan

In this issue...

Since the public health care system fails to deliver medically necessary services in a timely manner, provincial laws that effectively bar the private purchase of such services violate section 7 of the Charter of Rights and Freedoms.

The Study in Brief

Despite recent increases in provincial health budgets, long waits for many medically necessary services are common. At the same time, provincial barriers to the private purchase of services covered by the public system — provisions that support the monopoly funding condition of the *Canada Health Act* — prevent affected patients from accessing alternative treatments inside Canada.

The result is that Canadians who are ill are prevented from purchasing medically necessary services privately, while being denied timely access to such services in the public system.

This denial of access to timely medical care is a clear violation of the right to "security of the person" and to "liberty" guaranteed by section 7 of the Charter. Governments cannot tell Canadians that they are required to obtain medically necessary services exclusively through the public health care system and then deny them access to those services on a timely basis when they are ill.

Key court decisions have established that laws that are structured so as to fail to achieve their stated purposes are inconsistent with the principles of "fundamental justice." Since the purpose of public health care is to deliver timely medical services, denying access to such services while forbidding the use of private resources to obtain them is contrary to that purpose. For similar reasons, section 1 of the Charter, which permits limits to Charter rights that are reasonable or demonstrably justified in a free and democratic society, would also not justify these restrictions.

Constitutionally, governments are required to fund the public system so that it can provide reasonable access to medically necessary services or else permit citizens to purchase such services themselves. The corollary is that if Canadians are denied timely access to publicly financed care, the provincial prohibitions that suppress private medical services are legally unenforceable, and the federal government cannot use the financial penalties in the *Canada Health Act* to compel the provinces to enforce them.

The obvious obstacle to a section 7 challenge on these grounds is that patients with life-threatening illnesses will give priority to retaining the services of doctors, rather than lawyers, and may not survive the process. A practical response to this problem would be the involvement of an institution with sufficient financial resources to promote and fund litigation on behalf of patients. If the plaintiffs died before the case reached the Supreme Court of Canada, an appellate court could permit it to proceed to a final resolution.

The Authors of This Issue

Stanley H. Hartt is a former federal deputy minister of Finance and former chief of staff to the prime minister. *Patrick J. Monahan* is Associate Dean, Osgoode Hall Law School, York University, a former senior constitutional advisor to the premier of Ontario, and a Research Fellow of the C.D. Howe Institute.

* * * * * *

C.D. Howe Institute Commentary© is a periodic analysis of, and commentary on, current public policy issues. The manuscript was copy edited by Lenore d'Anjou and prepared for publication by Marie Hubbs and Barry A. Norris. As with all Institute publications, the views expressed here are those of the authors, and do not necessarily reflect the opinions of the Institute's members or Board of Directors.

To order this publication, please contact: Renouf Publishing Co. Ltd., 5369 Canotek Rd., Unit 1, Ottawa K1J 9J3 (tel.: 613-745-2665; fax: 613-745-7660), Renouf's store at 71½ Sparks St., Ottawa (tel.: 613-238-8985), or the C.D. Howe Institute, 125 Adelaide St. E., Toronto M5C 1L7 (tel.: 416-865-1904; fax: 416-865-1866; e-mail: cdhowe@cdhowe.org).

$12.00; ISBN 0-88806-557-4
ISSN 0824-8001 (print); ISSN 1703-0765 (online)

A decade ago, reform of the health care system barely registered as a problem for most Canadians. In spring 1992, with the country struggling to emerge from recession, public opinion surveys reported that economic concerns, such as jobs and taxes, were top-of-mind issues for Canadians; fewer than 5 percent of respondents mentioned health care as a public policy priority. But as governments reduced health care expenditures in the mid-1990s in an effort to eliminate budget deficits,[1] public concern and dissatisfaction with the state of the health care system grew exponentially. By 1998, health care emerged as the number one public policy priority in Canada, and, by 2000, more than three-quarters of Canadians indicated that they believed the health care system was in a crisis (see, generally, Vail 2001, 1–2).

Not unexpectedly, governments have responded to this growing public concern by resuming the previous practice of pumping significant additional dollars into provincial health care budgets each year.[2] But governments widely recognize that increasing funding alone cannot ensure the long-term sustainability of Canada's health care system.[3] Indeed, despite significant spending increases, the waiting lists for many types of medically necessary services seem to be getting longer rather than shorter.[4] The search for longer-term sustainable solutions to the pressures on the system has prompted an unprecedented number of government-sponsored royal commissions and inquiries in the past 12 months, many of them with a mandate to rethink the fundamental structure of the Canadian public health care system. In addition to the federal Royal Commission on the Future of Health Care in Canada, headed by former Saskatchewan Premier Roy Romanow,[5] a Senate

We are grateful for the very able research assistance of Heidi Rubin of Davies Ward Phillips & Vineberg LLP, the helpful comments on an earlier draft of this paper made by Peter Hogg, Peter Meekison, Bill Robson, Peter Russell, and Michael Walker, and the careful editing of Lenore d'Anjou and Barry Norris.

1 Health spending declined at a rate of 0.6 annually in real terms over the 1993–97 period (see Donaldson, Mitton, and Currie 2002, 23, figure 2).

2 CIHI (2001, chap 7) notes that estimates of public and private spending on health care topped $95 billion in 2000, 6.9 percent more than the previous year. In September 2000, the first ministers signed an agreement in which the federal government committed $23.4 billion to the provinces for health care through the Canada Health and Social Transfer.

3 For example, Robson (2001) argues that, over the next 40 years, an aging population will intensify the pressure on provincial health care budgets by eroding provincial tax bases. See also Canada 2002b, 6–12.

4 Walker with Wilson (2001) notes that the waiting time between referral from a general practitioner and treatment rose from 13.1 weeks in 1999 to 16.2 weeks in 2000–01. The Fraser Institute's annual survey of waiting times is sometimes criticized on methodological grounds, primarily that it involves surveys of physicians (which is said to make it subject to recall bias) and that the response rate is only about 25 percent of those who receive the mailed survey. Yet, as Walker and Wilson indicate, a number of other independent sources tend to corroborate their data on waiting times. Government bodies are also giving increasing, if grudging, recognition to the fact that waiting times are a significant public policy concern. See, for example, Alberta (2001, 19–20 — hereinafter the "Mazankowski Report") and Statistics Canada (2002). In response to growing public concerns over waiting times, the first ministers have agreed to track and report on readmissions and wait times in each of their jurisdictions by the end of 2002.

5 Hereinafter the "Romanow Commisssion," which is scheduled to report by November 2002. It has already published an interim report raising a number of issues for public discussion.

standing committee headed by Senators Michael Kirby and Marjory LeBreton,[6] and government-sponsored commissions in a number of provinces, have been simultaneously conducting hearings and publishing a variety of reports and proposals for wide-ranging structural reform of the health care system (Alberta 2001; Quebec 2000; Saskatchewan 2001; Strategic Counsel 2001).

All of this activity has generated a sense that fundamental reform is both urgent and imminent. As the Mazankowksi Report put it succinctly, the current health system "is not sustainable unless we are prepared to make major changes in how we fund and deliver health services" (Alberta 2001, 1). Mazankowski argues that health care expenditures are crowding out spending on other key public priorities, such as education, social services, and public security, and that the system is increasingly seen as failing to deliver timely access to medically necessary care. Canadians thus seem to be facing the worst of both worlds, with a health care system "structured like a 19th century cottage industry rather than a 21st century service industry" (Canada 2001a, xiii) that is, at the same time, consuming ever-increasing proportions of scarce public tax dollars.

Whether these strongly worded sentiments will actually produce concrete and meaningful reform remains to be seen. As many commentators note, the *Canada Health Act* has assumed almost mythical proportions, akin to a quasi-constitutional document, a view tending to rule out any discussion of significant changes to the act.[7] Despite the significant momentum that appears to be currently building in favor of major reform of the legislation, any meaningful change is certain to be controversial and politically costly,[8] and it is not clear that risk-averse political leaders at the provincial or federal level are prepared to bear those costs.

The Charter as a Factor

The present system for delivering health care services in Canada possibly violates the constitutionally protected rights of Canadians.

Yet an additional factor, although largely ignored thus far in the debate, may make the status quo legally as well as politically unsustainable. This additional element is the possibility that the present system for delivering health care services in Canada violates the constitutionally protected rights of Canadians, guaranteed by section 7 of the Canadian Charter of Rights and Freedoms.

The introduction of the Charter two decades ago has fundamentally transformed many areas of public policy debate in Canada, with governments increasingly required to consider, as a routine matter, whether their legislative and regulatory proposals run afoul of constitutionally entrenched rights.[9] Yet the debate over health

6 Between September 2001 and April 2002, this committee published a number of separate reports on the state of the health care system, in both Canada and other jurisdictions, and set out possible options for reform (see Canada 2001a; 2002b). Further reports are planned for later in 2002.

7 The Romanow Commission comments that the "iconic status" of the *Canada Health Act* has made it "virtually untouchable by any politician." Thus, the act is "virtually immune to reform, improvement or expansion — and this could, over the long term, diminish one of our proudest national achievements" (Canada 2002a, 3). For similar comments, see Canada (2001a, xiv).

8 Consider, for example, the huge controversy sparked by the relatively modest reforms Alberta undertook in 1999 and 2000 through the *Health Care Protection Act* (Bill 11), which permits public funding of some medical services performed in private clinics.

9 Some critics decry this tendency, alleging that the courts have been overstepping their role and usurping the responsibilities of the legislature. See, in particular, Morton and Knopff (2000). For a response, see Roach (2001).

care reform has not generally included constitutional issues or entitlements. One reason is, doubtless, that the courts have tended to give short shrift to the relatively few claims advanced in the health care field, largely by health care professionals challenging restrictions on their right to practice their profession.[10] Those few cases advanced on behalf of patients have met with the response that the Charter can be used as a shield to protect citizens *from* government action but not as a sword to compel government *to act*. Thus, some commentators argued that the Charter cannot be used to guarantee citizens a certain absolute level or quality of health care services, since doing so would be improperly use it as a sword rather than a shield. (See Canadian Bar Association 1994, 19–26; and Canada 2001b, testimony of Professors Martha Jackman and Sheilah Martin.)[11]

We accept that the Charter of Rights does not guarantee a right to health care or to a public health care system structured in a particular fashion.[12] But this observation does not tell us whether government attempts to discourage or prohibit the emergence of a private health care system might be vulnerable to a constitutional challenge.

When we consider the constitutionality of restrictions of this type, the issue is no longer whether the Charter can be used to *compel* government to act; governments have *already* acted by prohibiting citizens from using their own economic resources to purchase medically necessary services. The issue that arises is whether Canadian governments are limited in their ability to impose these kinds of restrictions.

Existing restrictions on the private purchase of medically necessary services are entirely justifiable in circumstances where such medical services are available on a timely basis through the public system.

In our view, existing restrictions on the private purchase of medically necessary services are entirely justifiable in circumstances where such medical services are available on a timely basis through the public system. In other words, we see no basis for claiming that the Constitution guarantees a *generalized* right to purchase medical services privately. But what if timely access to medically necessary services is denied in the public system, and governments simultaneously prohibit or impede Canadians' ability to access such services privately?

This question, which thus far has largely been ignored in the debate over health care reform,[13] is the focus of this paper. We conclude that, where the publicly funded health care system fails to deliver timely access to medically necessary care,

10 The basis of rejection has generally been that the Charter does not guarantee the right to work or to practice one's profession free of government regulation. See, for example, *Walker v PEI* (1995), and *Rombaut v New Brunswick (Minister of Health and Community Services)* (2000). An early decision of the British Columbia Court of Appeal, *Wilson v BC Medical Services Commission* (1988), which held that regulations restricting the mobility of doctors within a province violated the section 7 right to liberty, has not been followed by subsequent courts.

11 Of course, courts have been receptive to Charter claims based on unequal or differential access to a given health care service, but such claims have been advanced on the basis of the section 15 guarantee of equality rights. (See, for example, *Eldridge v British Columbia* (1997), which ruled that a hospital's failure to provide sign language interpretation for hearing-impaired patients violated their right to equality.) Such equality-based claims are very different from one that the Constitution guarantees a positive right to health care, a claim that the Courts have not yet accepted.

12 Certain commentators claim that the Constitution guarantees a minimum level of social entitlements. (See, for example, Jackman 1988; and Johnstone 1988.) We do not share this view.

13 The Kirby-LeBreton Committee has indeed squarely raised this precise question and heard expert testimony on the subject, but has yet to offer a definitive view or conclusion (Canada 2001a, 40; 2002b, 59–60). Other helpful discussions of the possible use of section 7 to challenge delays in the availability of medically necessary services are Karr (2000); Canadian Bar Association (1994, 93–95); and Jackman (1995). See also Flood and Archibald (2000), who discuss the extent to which...

governments act unlawfully in prohibiting Canadians from using their own resources to purchase those services privately in their own country. In these circumstances, the restrictions on private payment and private health insurance that are found in the laws of the various provinces force Canadians into a system that, at a minimum, compromises their health and potentially may endanger their lives. This form of conscription engages the values protected by the Charter, particularly the right to "life, liberty and security of the person" guaranteed by section 7. To restate the point, if a government rations the supply of health care services, thereby failing to provide Canadians with timely access to medically necessary services through the publicly funded system, it cannot simultaneously prevent individuals from purchasing such services outside of that flawed system.

The current prohibitions on private purchase of medical services are, therefore, constitutionally unenforceable.

These circumstances are precisely those that Canadians face at the present time. The current prohibitions on private purchase of medical services are, therefore, constitutionally unenforceable. Moreover it would be constitutionally improper for the federal government to use the financial penalties provided under the *Canada Health Act* in an effort to compel provinces to enforce such constitutionally suspect prohibitions. Yet our analysis does not necessarily lead to the conclusion that governments must loosen the current restrictions on the ability to access private medical services. The constitutionally required remedy is for government *either* to fund and organize the public system so it can provide reasonable access to medically necessary services *or*, if timely access continues to be denied, to permit citizens to purchase such services with their own resources.

If the policy choice is to prohibit individuals from such private purchases, governments must meet minimum constitutional guarantees of fairness and justice. In particular, they must ensure that individuals, in return for giving up private access to medical services, are provided with reasonable access to those services in the public system. It is the failure to satisfy this minimum standard of fairness that gives rise to the constitutional argument we explore in this *Commentary*.

Outline of the *Commentary*

Before turning to the constitutional arguments that are the focus of this *Commentary*, we begin with a concrete example that illustrates and illuminates the nature of our analysis. The case is that of Barry Stein, a Quebec resident who was forced to go to the United States to obtain needed cancer surgery in 1996 and 1997. He later sought reimbursement from the Quebec health insurance plan for the costs of his treatment, and, when the plan denied his claim, he sought judicial review in the courts. The facts and circumstances of the *Stein* case put a human face on the kinds of difficult life-and-death choices ordinary Canadians face when they confront unacceptable delays in accessing medically necessary treatment.

We then consider how these delays could be the basis of a constitutional challenge. We focus on section 7 of the Charter and, in particular, that section's guarantees of "security of the person" and "liberty." We explain that the courts have determined that where delay in the provision of medically necessary services

---

Note 13 - cont'd.

...various provincial health schemes prohibit or limit the ability of Canadians to access medically necessary services privately; we have found this paper very helpful.

results in a danger to an individual's life or health, that individual's liberty and security of the person have been violated.

We also review the somewhat conflicting evidence on the extent and nature of waiting times for medically necessary services. Although governments initially resisted claims that Canadians are being forced to wait for periods longer than medically appropriate, more recent government-sponsored studies accept that waiting times are too long and constitute a significant public policy problem. We also consider the monopoly nature of the public health care system, in particular, the fact that it is designed to prohibit outright or to effectively prevent the emergence of a private market for insured medical services.

The most difficult and uncertain aspect of a section 7 challenge to the existing delivery of public health care services is whether the limitations on access to timely medical care can be said to be inconsistent with the "principles of fundamental justice" guaranteed under that section. The main reason for this uncertainty is that the courts have yet to define, in a definitive or comprehensive fashion, the meaning of those words. Yet the courts have held that some laws that are structured so that they fail to achieve their stated purposes are inconsistent with the principles of fundamental justice under section 7. The entire rationale and purpose of the public health care model is to deliver timely medical services to Canadians. To deny them access to timely care in the public system and to simultaneously prevent them from using their own resources to access such services is directly contrary to that stated purpose. Thus, the relevant laws and regulations cannot be consistent with the principles of fundamental justice.

Next, we consider the assumption that a court finds a violation of section 7 for the reasons we discuss. Would it be willing to permit the violation pursuant to section 1 of the Charter? As we note, the courts have devised a special rule for applying the two sections to the same set of circumstances: section 1 can be used to justify section 7 violations in only the most exceptional circumstances, such as war or famine. Plainly, no such exceptional condition exists in the present case.

The existing legal structure for the delivery of public health care services violates the constitutional rights of Canadians who are denied timely access to medically necessary care.

We conclude that the existing legal structure for the delivery of public health care services violates the constitutional rights of Canadians who are denied timely access to medically necessary care. Thus, the various provincial statutes' current prohibitions whose purpose or effect is to suppress the availability of private medical services are legally unenforceable. Moreover, the federal government cannot use the financial penalties in the *Canada Health Act* in a manner that compels the provinces to enforce such invalid prohibitions.

The *Commentary* ends by considering the practical obstacles to mounting a constitutional challenge on the grounds we describe. The most significant hurdle is a lack of money and time: any patient with a life-threatening illness will give priority to retaining the services of doctors, rather than lawyers. We therefore consider ways of overcoming these practical obstacles so that a court would be provided with a timely opportunity to consider these important constitutional issues.

An Illustration: The *Stein* Case

The nature of our argument can best be illustrated through consideration of a concrete set of facts. Consider, in that regard, the experience of Quebec resident

Barry Stein with the Quebec health care system, as revealed in the record of his 1999 case before the Quebec Superior Court (*Stein v Québec Régie de l'Assurance-maladie*).

Mr. Stein, then a 41-year-old father of three children, was diagnosed with colon cancer in late 1995. In early January 1996 he was operated on in Montreal and had a foot-long section of his colon removed. Unfortunately, the surgeons discovered cancerous liver lesions, which could not be removed during the operation because of their placement and number and because of the lack of a key piece of medical equipment.

Stein's doctors strongly recommended that these lesions be removed as soon as possible after he recovered from the colon surgery and not later than four to eight weeks from the date when they were first detected. The liver surgery was scheduled three different times between January and April 1996, only to be canceled on each occasion due to hospital overcrowding and to the classification of this surgery as elective. On the third of these occasions, April 2, 1996, Stein was sent home after having spent the day lying in a hospital bed and expecting to be wheeled into the operating room at any moment.

It was now nearly three months since the cancerous lesions had been discovered, and they had still not been removed. On April 8, 1996, Stein's doctors wrote to the Régie de l'assurance-maladie du Québec requesting authorization to send him for surgery to New York City, where a full range of treatments would be available. On April 12, 1996, the Régie refused this request on the grounds that certain of the procedures that the patient wanted performed had not been proven to improve survival rates. The Régie also suggested that its policy was to fund medical services outside Canada only when they were not available elsewhere in the country. Some of the services Stein wanted, said the Régie, were available from doctors elsewhere in Canada; it provided him with the names of those doctors and suggested he get in touch with them.

Stein contacted the Régie to explain that the alternatives being offered were inadequate and that it should grant his request to have the surgery performed in the United States.[14] The Régie's doctor (who had written the letter refusing his request) spoke with the patient and told him that he should forget further surgery and live his remaining days in peace.

The Régie's doctor told the patient that he should forget further surgery and live his remaining days in peace.

Stein reacted with shock and disbelief. He decided instead to follow his doctors' recommendations and went to New York for two operations, which occurred in April 1996 and January 1997. Two years later, medical tests showed that he was free of any recurrence of liver lesions. The surgery had saved his life or, at a minimum, significantly prolonged it.

14 The Régie had apparently not asked the suggested Canadian surgeons whether they were actually available to perform the required surgery on a timely basis, taking into account the fact that Stein had already been waiting for 12 weeks. Moreover, these surgeons were not in a position to perform all the surgery that Stein's doctors were recommending, since some of the services were classified by the Régie as experimental and were not available anywhere in Canada. In short, the alternatives the Régie proposed were theoretical possibilities that might have led to certain services being provided at some unknown time in the future, whereas Stein himself had already undertaken extensive investigations and identified medical facilities in the United States where all the required surgery could be provided immediately.

Stein then claimed reimbursement for the costs of the treatments, relying on certain provisions in the *Health Insurance Act*.[15] The Régie refused Stein's claim on a number of grounds. First, while acknowledging that a delay of more than six weeks in obtaining the liver surgery would have been dangerous for Stein, the Régie argued that since he had requested authorization to have the surgery in New York only on April 8, 1996, and it was actually performed there just eight days later, there was no evidence that he had been subjected to an unacceptable delay. The Régie also found that the second surgery performed in New York was experimental, since it was not then being performed in Canada, and was therefore not eligible for reimbursement.[16]

Stein appealed this decision to an administrative tribunal, which upheld the Régie's refusal to reimburse. But he was persistent and sought judicial review of the tribunal's decision in the Quebec Superior Court. Justice Carol Cohen held that the Régie's refusal to reimburse Stein was patently unreasonable, since it had failed to recognize that Stein had requested treatment in New York in April precisely because the surgery was not being performed in Montreal in a timely fashion, and because it was more than 12 weeks since the liver lesions had first been discovered. The court found:

> [T]o maintain that it was reasonable to make Stein continue to wait for surgery in Montreal when the danger to his well-being increased daily is irrational, unreasonable and contrary to the purposes of the Health Insurance Act, which is designed to make necessary medical treatment available to all Quebecers. (Stein 1998, paragraph 32.)

The decision was only that the Régie had failed to interpret its own enabling statute properly.

The *Stein* case was brought on extremely narrow grounds. Stein's argument was that, on a proper interpretation of Quebec's *Health Insurance Act*, he had a statutory right to be reimbursed under Quebec law.[17] In effect, the decision was only that the Régie had failed to interpret its own enabling statute properly. The court was not asked to consider whether an underlying *constitutional* claim or entitlement could have been raised on Stein's behalf.

The potential existence of such a constitutional entitlement would evidently be of particular importance to any Canadians who found themselves in a dilemma similar to the one Stein experienced. The court's 1998 holding in *Stein*, although

15 Section 10, which provides that a beneficiary under the health insurance plan is entitled to be reimbursed for the cost of insured services provided outside Quebec. Pursuant to regulations made under the act, services abroad are reimbursed only if the service is not available elsewhere in Canada, and no reimbursement is provided for services classified as experimental (*Stein* 1998, paragraphs 24–26).

16 The surgery in question was routinely available in the United States but was not available in Canada because of the cost of a necessary medical device. However, the Régie classified any procedure not available in Canada as experimental and, on this basis, deemed the procedure not eligible for reimbursement. As the Superior Court judge who reviewed the matter noted, this approach is "irrational" since it "imposes a tautology that will prevent the coverage of all procedures performed regularly elsewhere but not within the country" (ibid., paragraph 42).

17 There was further litigation over the extent to which the Régie was obliged to compensate Stein for his legal costs. In *Stein v Quebec (Régie de l'Assurance-maladie)* (2000), the Quebec Superior Court ordered the Régie to pay a "special fee" of $18,000 due to the importance of the case, rejecting the Régie's claim that the case was not important.

important, simply establishes that, given the facts of his particular case, Quebec law affords a right for reimbursement of medically necessary services provided outside of the province. But statutes can be amended by the legislature. Thus, the statutory right recognized in *Stein* is vulnerable to being narrowed or even eliminated entirely by the Quebec National Assembly through an ordinary statutory or regulatory change.

Further, the reasoning in *Stein* has no application outside Quebec, since statutory regimes governing the right to reimbursement for medical services obtained out of province vary from one province to another. Indeed, only Ontario and Quebec have arm's-length administrative tribunals to deal with claims that the provincial health insurance plans should fund particular treatments outside of the province.[18] Moreover, the relevant statutes typically give an extremely narrow definition of the circumstances in which a resident is entitled to reimbursement for out-of-province services.[19]

Do Canadians have any legal right to complain about the fact that they are now commonly required to travel outside their home province and, indeed, outside the country in order to obtain timely access to medically necessary services?

More important, *Stein* does not address a broader underlying issue that the facts of the case highlight: do Canadians have any legal right to complain about the fact that they are now commonly required to travel outside their home province and, indeed, outside the country in order to obtain timely access to medically necessary services?[20] The facts of *Stein* illustrate the enormous discrepancy in the availability of such essential services; after unsuccessfully attempting for 12 weeks to obtain needed surgery in Montreal, Stein was able to obtain the procedure in New York City on four days' notice. But not all Canadians are as resourceful as Stein, who had the wherewithal to research the available treatments, consult with various experts as to the treatment advisable for his condition, identify appropriate specialists in New York City to perform the surgery on short notice, and finance the travel and treatment.

The Elements of a Section 7 Claim

Stein apparently raised no objection to the fact that the services he needed to save his life were not available in Quebec and that he was therefore forced to navigate the US health care system. All he wanted was to be reimbursed his out-of-pocket expenses. The question, however, is whether Canadians have any right to complain when medically necessary services that are routinely available in the United States are denied them in Canada and their governments prohibit them from purchasing such services here with their own resources. It is to a consideration of this broader question that we now turn.

We believe that the facts of the *Stein* case and, by extension, the current legal regime governing the public health care system squarely raise a claim under the Charter's section 7, which guarantees:

18 For a helpful discussion of the various provisions in provincial health statutes providing for reimbursement of out-of-province health costs, see Flood and Epps (2001).

19 In Ontario, for example, reimbursement is available for services provided out of province only where a delay in treatment would "result in death or medically significant irreversible tissue damage" (regulation 552 made under the *Health Insurance Act*, section 28.4).

20 Media reports of Canadians' being forced to obtain medical services in the United States are increasingly common. Some of the recent accounts include Priest (2002a; 2002b), McCarthy (2002), Arnold (2001a; 2002b); and Talaga (2000). As we argue below, these media accounts are not reports of mere anomalies but reflect broader, systemic problems in the delivery of health care on a timely basis to Canadians.

> 7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

The courts have made it clear that a constitutional claim based on section 7 must comprise *three* distinct components:

- An action of a legislature or government must deprive a person of one or more of "life, liberty or security of the person," which are the interests protected under section 7 of the Charter.
- This deprivation must be contrary to the principles of fundamental justice.
- The violation cannot be justified under section 1 of the Charter, which requires that a violation of a protected right is a "reasonable limit" that can be demonstrably justified in a free and democratic society.

The next sections of this *Commentary* turn to a consideration of each of these elements of a section 7 claim.

Deprivation of Security of the Person

Government measures that prevent individuals from accessing timely and appropriate health care services clearly constitute a violation of security of the person under section 7 of the Charter.

Although the courts have not fully elaborated the precise meaning of the phrase *security of the person*, government measures that prevent individuals from accessing timely and appropriate health care services clearly constitute a violation of it under section 7. The Supreme Court made this decision in *R v Morgentaler* in 1988, unanimously taking the view that government procedures that caused a delay in the provision of abortion services constituted a violation of both the physical and the psychological aspects of women's security of the person.

The evidence in *Morgentaler* indicated that the administrative steps established under the applicable *Criminal Code* provisions caused women who qualified for abortions to experience a delay of one to eight weeks in obtaining the procedure; although the overall complications and mortality rates for women who underwent it were relatively low, a delay of this magnitude materially increased them. Chief Justice Dickson, with whom Justice Lamer concurred, stated that since the increased risk resulting from the delay in obtaining an abortion was "clearly established," there had been a deprivation of security of the person.

> It is no doubt true that the over-all complication and mortality rates for women who undergo abortions are very low, but the increasing risks caused by delay are so clearly established that I have no difficulty in concluding that the delay in obtaining therapeutic abortions caused by the mandatory procedures of s. 251 is an infringement of the purely physical aspect of the individual's right to security of the person. (*Morgentaler* 1988, 59.)

Chief Justice Dickson was also of the view that the delay caused by the administrative procedures violated the *psychological* aspect of security of the person, since

> [T]here is increased psychological stress imposed upon women who are forced to wait for abortions, and ... this stress is compounded by the uncertainty whether or not a therapeutic abortion committee will actually grant approval. (Ibid., 60.)

In the course of his analysis, Chief Justice Dickson dealt specifically with the circumstances in which women could access an abortion only by traveling to another part of the province or to the United States. In his view, it was inappropriate to say "let them travel," since the requirement to go long distances imposed an "enormous emotional and financial burden" (ibid., 71). He also noted that certain Toronto and Hamilton hospitals had been forced to establish "arbitrary abortion quotas," which resulted in further delays or caused women to "become desperate and choose to travel even further afield, to Quebec or the United States, to obtain an abortion in a free-standing clinic" (ibid., 72). In other words, even though the procedure in question might be available in another jurisdiction, if the woman seeking access to an abortion was required to travel long distances to obtain the procedure and if such a travel requirement caused a delay that increased the medical risks of complication, her security of the person was breached.

Justices Beetz and Wilson reached similar conclusions in their opinions in *Morgentaler*. For example, Justice Beetz (with whom Justice Estey concurred) found that security of the person "must include some protection from state interference when a person's life or health is in danger" (ibid., 90). The evidence demonstrated that administrative procedures established under the Code, including quotas on the numbers of abortions to be performed, resulted in significant delays in obtaining access to the procedure. Since these delays increased the risk of postoperative complications, Justice Beetz found a violation of security of the person in both its physical and its psychological aspect (ibid., 101).[21]

Application to Health Care Legislation

How does this analysis of *Morgentaler* apply to legislative restrictions on citizens' ability to access health care services privately?

The extent to which Canadians are being denied timely access to medically necessary services has been a fiercely contested topic in debates over health care reform over the past decade.

The extent to which Canadians are being denied timely access to medically necessary services has been a fiercely contested topic in debates over health care reform over the past decade. Until recently, little or no information on waiting times was publicly available. Moreover, suggestions that waiting times for medically necessary services constitute a significant public policy problem were initially denounced as "at best misleading...and at worst instruments of misinformation, propaganda and general mischief" (McDonald et al. 1998).[22] Health care economists argued that the existence of waiting lists did not prove that the level of delivered services was insufficient; rather, waiting lists were said to be a natural phenomenon that arises when the price of care to patients is zero and the method of paying physicians is fee for service (see, for example, Marmor 1998, 11–12). Moreover, Marmor claimed that wait lists are a "managerial tool for allocating resources" and that physicians have an incentive to put patients on them insofar as they create

21 The third majority opinion, written by Madam Justice Wilson, focused primarily on the liberty interest protected by section 7. However, she too agreed that the provisions in question violated a woman's security of the person, for essentially the same reasons (ibid., 173–174).

22 A particular target for criticism has been the pioneering and important work of the Fraser Institute over the past decade in attempting to compile data on waiting times (see, for example, Walker with Wilson 2001).

public pressure to increase funding for specific medical procedures (ibid., 12). Finally, when concerns over waiting times initially emerged in the mid-1990s, Canadians were urged to take comfort in the fact that the country's overall mortality rate was low and its life expectancy long (ibid., quoting various sources).

Enforced Rationing of Medical Treatment

In the past five years, Canadians have seen mounting evidence that waiting lists represent a rationing of health care services.

In the past five years, however, Canadians have seen mounting evidence that waiting lists represent a rationing of health care services — that is, enforced waiting for medical treatment — rather than a mere managerial tool for allocating resources. Certainly Stein's unhappy experience with the Quebec health insurance plan, in which potentially life-saving surgery was classified as elective or experimental, thereby leading to its repeated cancellation or postponement, seems by no means unique or uncommon.

In the recent case of *Kramer v The Ontario Health Insurance Plan* (OHIP 2002), the facts of which are somewhat analogous to *Stein*, Ontario resident Ronald Kramer had been denied permission to obtain life-saving cancer treatment in the United States on the grounds that the treatment in question was experimental, even though it was widely available in Ontario and elsewhere in North America and was being funded by the OHIP at five of eight regional cancer centers in the province.[23] Had Kramer undergone the more limited surgical procedure that his treating physician offered him, the expected five-year survival rate was in the 10–20 percent range, whereas the treatment available in the United States had a five-year survival rate of 50–60 percent. Even though OHIP denied Kramer's June 1998 application to obtain the treatment outside the country, he opted to pay $350,000 out of his own pocket and have the treatment provided at the Johns Hopkins Oncology Centre in Baltimore, Maryland.

Nearly four years later, Ronald Kramer showed no evidence of cancer. Yet OHIP denied his claim for reimbursement on the same grounds as it had refused his original request for permission to have the treatment performed in the United States — namely, that the treatment in question was experimental. Kramer appealed this decision to the Health Services Appeal and Review Board, which found that the treatment was standard, in both Ontario and the United States, for the type of cancer Kramer had experienced. The Review Board ordered OHIP to reimburse him the $350,000 he had spent, on the grounds that had he waited to obtain the treatment in Ontario, he would have suffered a delay resulting in "death or significant irreversible tissue damage" (which is the statutory requirement of obtaining reimbursement).

A further illustration of inappropriate waiting time for treatment in Ontario is provided by the case of Ralph Smith, a 53-year-old Ottawa man who was diagnosed with prostate cancer in early 2001 (Kirkey [2002] sets out the facts of the case). A

23 The specialists to whom Kramer was referred in early 1998 did not offer the particular treatment he sought and were unaware of its availability elsewhere in the province. The OHIP officials who rejected Kramer's request were likewise unaware. Not until early 2001 did Kramer's treating physician learn that the treatment was widely available in Ontario. He brought that fact to the attention of OHIP, but it continued to resist Kramer's request for reimbursement on the grounds that the treatment was experimental.

routine blood test showed Smith had suspiciously high levels of a protein linked to prostate cancer. But he had to wait five months to see a specialist, who performed a biopsy and confirmed the presence of an aggressive tumor. Smith was then told that he would have to wait an additional three to four months to receive the needed surgery. Rather than delay, Smith arranged to have the surgery performed in England in May 2001 and left before OHIP had a chance to rule on his application for out-of-country treatment.

OHIP eventually refused to reimburse Smith the $17,000 he had spent on his treatment on the grounds of lack of proof that the additional delay was anything other than appropriate. However, Smith appealed this decision to the Health Services Appeal and Review Board, which, in March 2002, ordered OHIP to reimburse him on the grounds of sufficient evidence to show that there was a delay in getting treatment that would result in significant tissue damage or death.

Symptoms of Systemic Problems

What is becoming increasingly clear is that these individual cases are not mere anomalies or exceptions but, rather, symptoms of broader, systemic problems in the delivery of medically necessary health care. A landmark study (Simunovic et al. 2001), recently published in the *Canadian Medical Association Journal*, tracks the waiting times experienced by 1,456 patients diagnosed with breast, prostate, colorectal, or other cancers in Ontario between January and May 2000. The Canadian Society of Surgical Oncology has stated that, for the average cancer patient, the time from completion of diagnostic tests to definitive surgery should not exceed two weeks. But Simunovic and his partners say that 37 percent of the patients studied exceeded this appropriate wait period, and the median wait time for surgery for certain cancers was nine weeks. The factors most often contributing to these medically inappropriate delays were shortages of operating room time or lack of other resources, such as diagnostic tests or allied health personnel. Further, Statistics Canada (2002) acknowledges that one in eight Canadians reports having "unmet health care needs," triple the number of Canadians reporting unmet health care needs in 1994/95. The two most common reasons cited for such unmet health care needs are waiting times and the unavailability of services.

The two most common reasons cited for unmet health care needs are waiting times and the unavailability of services.

Government-sanctioned commissions now appear to have accepted that waiting times for medically necessary services in Canada are unacceptably long and represent a significant public policy problem that must be addressed on an urgent basis. For example, the recent interim report of the Romanow Commission makes no attempt to dismiss concerns over waiting lists as a natural phenomenon or a media fabrication. Rather, it acknowledges that "problems of access and waiting times are serious ones indeed and serve to undermine the confidence of Canadians that the health care system will be there when they need it" (Canada 2002a, 31).[24] The Mazankowski Commission concludes that concerns over waiting times and access

24 According to this report, waiting times for "elective and non-emergency surgery is common." The causes are attributed to a failure to manage resources effectively, a shortage of health care professionals, lack of operating room capacity, and a shortage of hospital beds. The report also notes that "waiting months to see a specialist is Canadians' major frustration with health care" (Canada 2002a, 30).

represent the number-one concern of Albertans and acknowledges that waiting times for many medically necessary services are too long (Alberta 2001, 19–20).

Federal and Provincial Regulation: An Interlocking Scheme

When governments ration access to a service that the public demands, the expected reaction is for individuals to seek to obtain that service from the private sector. But this normal reaction is not possible for health care since a complex and interlocking scheme of regulation, at the federal and provincial levels, effectively prevents the emergence of a private market for health care.

The interlocking scheme of regulation begins with the *Canada Health Act*, 1985 (CHA). The act does not itself prohibit the provision of medically necessary services outside of the publicly funded system. Rather, it merely sets out the conditions that a provincial health insurance scheme must meet before it is entitled to full federal funding.[25] These federal conditions include the famous five principles: public administration, comprehensiveness, universality, portability, and accessibility (section 7). The CHA also provides (sections 18–20) that if a province permits extra-billing or user charges, the federal cash contribution is reduced by their amount, dollar-for-dollar.

The Canada Health Act *does not itself prohibit the provision of medically necessary services outside of the publicly funded system.*

Provincial legislation complements these restrictions, effectively prohibiting the provision of medically necessary services outside the publicly funded system. The relevant restrictions in the various provinces can be grouped into the following categories:[26]

- Physicians who are enrolled in a provincial health plan either cannot directly bill patients who are insured under it for any amount in respect of an insured service (Ontario, British Columbia, Manitoba, Newfoundland, Nova Scotia, and Quebec) or cannot bill patients for any amounts exceeding those amounts payable under the relevant provincial health insurance scheme (all provinces except Prince Edward Island and New Brunswick).[27]

25 Section 4 of the CHA describes the purpose of the act as to "establish criteria and conditions in respect of insured health services ... provided under provincial law that must be met before a full cash contribution may be made."

26 The following summary draws on the analysis set out in Flood and Archibald (2000).They point out that provincial law does not expressly prohibit the private purchase of medical services outside the public health care system, but the purpose and effect of the prohibitions is to suppress the availability of such services. Thus, although individuals could theoretically purchase such services if they were offered, they are not, in fact, available for purchase, which renders the theoretical right to purchase them wholly illusory.

27 For Ontario, see *Health Insurance Act*, sections 15(3)(b) & (c); for British Columbia, see *Medicare Protection Act*, sections 10(1), 17(1), and 18(3); for Manitoba, see *Health Services Insurance Act*, sections 93 and 95(1); for Newfoundland, see *Medical Care Insurance Act*, 1999, sections 7(1) and 8(1); for Nova Scotia, see *Health Services and Insurance Act*, sections 27(1) and 29; for Quebec, see *Health Insurance Act*, sections 14, 22, 30 and 31; for Alberta, see *Alberta Health Care Insurance Act*, sections 5.2, 5.31(2), 5.05(2) and 5.5(1); for Saskatchewan, see *Saskatchewan Medical Care Insurance Act*, sections 18(1) and 24.1; for New Brunswick, see *Medical Services Payment Act*, sections 2.01(a), and *General Regulation — Medical Services Payment Act*, schedule 2, para. (n.1); and for Prince Edward Island, see *Health Services Payment Act*, section 14.1. Under a narrow exception in British...

The Meaning of *Principles of Fundamental Justice*

As explained earlier, the mere fact that a statute or government decision restricts liberty or security of the person is not sufficient, in and of itself, to cause a violation of section 7. In addition, someone must demonstrate that the restriction is inconsistent with the principles of fundamental justice. The courts have held that fundamental justice includes both a procedural and a substantive component. However, the precise meaning of the term *fundamental justice*, particularly in its substantive aspect, remains elusive.

The precise meaning of the term fundamental justice, *particularly in its substantive aspect, remains elusive.*

In the *Reference re B.C. Motor Vehicle Act* (the seminal decision in which the Supreme Court determined that fundamental justice has both a substantive and a procedural component) Justice Lamer stated that "the principles of fundamental justice are to be found in the basic tenets of the legal system." However, he also said that the phrase *fundamental justice* "cannot be given any exhaustive content or simple enumerative definition, but will take on concrete meaning as the courts address alleged violations of s. 7" (1985, 503).

Subsequent decisions have not offered a more precise definition of the term. The opinions in certain cases have suggested that the proper approach is to ask whether "from a substantive point of view, the change in the law strikes the right balance between the [individual's] interests and the interests of society" (*Cunningham v Canada*, 1993, 152). In other cases, the Supreme Court has suggested that principles of fundamental justice must be fundamental "in the sense that they would have general acceptance amongst reasonable people" (*Rodriguez v British Columbia* 1993, 607).

Some Insights from Morgentaler

Despite the rather vague nature of the formulations just quoted, the 1988 *Morgentaler* case features a helpful discussion of the application of the principles of fundamental justice when access to necessary medical services is delayed. In his opinion in that case, Chief Justice Dickson noted that the *Motor Vehicle Reference* decision had indicated that the principles of fundamental justice are to be found in the "basic tenets of our legal system." According to the Chief Justice, one of the basic tenets of our legal system is that "when Parliament creates a defence to a criminal charge, the defence should not be illusory or so difficult to attain as to be practically illusory" (1988, 70). For access to abortion, Parliament had determined that a woman whose life or health is in danger should be entitled to obtain an abortion without fear of criminal sanction. However, the administrative system that had been put in place to provide such access had failed to ensure that women who met the parliamentary standard could actually obtain the procedure. That procedure was therefore "manifestly unfair" and contrary to the principles of fundamental justice.

> It [the administrative structure under section 251] contains so many potential barriers to its own operation that the defence it creates will in many circumstances be practically unavailable to women who would *prima facie* qualify for the defence, or at least would force such women to travel great distances at substantial expense and inconvenience *in order to benefit from a defence that is held out to be generally available.* (Ibid., 72–73, emphasis added.)

Chief Justice Dickson emphasized that the provinces must be given room to make choices about the proper administrative structures for the delivery of health services. However, an administrative structure that is manifestly unfair cannot be regarded as being consistent with the principles of fundamental justice. Such unfairness arises when a medical procedure is held out as being generally available, but barriers block access to the service so that it is practically unavailable or available only at great cost or expense.

The reasoning of Justice Beetz in *Morgentaler* on the meaning of the principles of fundamental justice is also instructive. The principles of fundamental justice, he wrote, require that the administrative structures put in place to determine the availability of abortion be fair. And he defined *fairness* in the following terms:

> A fair structure, put in place to decide between those women who qualify for a therapeutic abortion and those who do not, should be designed with a view to *efficiently meeting the demands which it must necessarily serve.* (Ibid., 114, emphasis added.)

Justice Beetz was of the view that a statute would satisfy this "efficiency" standard only if the procedures it established could be justified in terms of Parliament's objectives. He pointed out that many of the procedural requirements in this case could not be justified in terms of those objectives, which he identified as protecting the foetus as well as the life and health of the mother. These shortcomings were such that the statute, "considered as a whole, violates the principles of fundamental justice" (ibid., 121–122).

Although Parliament has a legitimate interest in protecting the foetus, this interest does not extend to total denial of access to an abortion in circumstances where a woman's life or health is at risk.

Justice Beetz refrained from specifying the extent to which Parliament could restrict a woman's access to an abortion in order to protect the foetus. However, he specifically found that completely removing the exculpatory provisions of the *Criminal Code* could not be justified in the interests of protecting the foetus (ibid., 126, 128). In other words, although Parliament has a legitimate interest in protecting the foetus, this interest does not extend to total denial of access to an abortion in circumstances where a woman's life or health is at risk. This finding is important, since it clarifies that laws prohibiting individuals from accessing medical procedures that are necessary to their life or health cannot be justified under the Constitution.

The Implications of Restrictions on Access

In our view, this reasoning can apply directly to the issue of whether restrictions on access to timely and appropriate medical services are consistent with the principles of fundamental justice.

We begin with the proposition that the current restrictions on access to private medical care are premised on the assumption that the publicly funded system will provide Canadians with timely and appropriate medical care. For example, the preamble to the CHA states that Parliament, in enacting the legislation, recognizes that "continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians," and that it wishes to "encourage the development of health services throughout Canada by assisting the provinces in meeting the costs thereof." And section 3 of

the act specifies that the "primary objective" of Canadian health care policy is to "protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."

Various provincial statutes regulating the delivery of health care services contain similar statements and commitments. For example, the preamble to British Columbia's *Medicare Protection Act* states that the "people of British Columbia believe that medicare is one of the defining features of Canadian nationhood and are committed to its preservation for future generations" and that the "people and government of British Columbia believe that it is fundamental that an individual's access to necessary medical care be solely based on need and not on the individual's ability to pay."

The First Ministers' Communiqué on Health of September 2000 describes their vision of health care in a similar manner:

> *Canadians will have publicly funded health services that provide quality health care and that promotes the health and well-being of Canadians in a cost-effective and fair manner.*
>
> *First Ministers believe* that the key goals of the health system in Canada are to: preserve, protect and improve the health of Canadians; ensure that Canadians have reasonably timely access to an appropriate, integrated, and effective range of health services anywhere in Canada, based on their needs, not their ability to pay; and, ensure its long-term sustainability so that health care services are available when needed by Canadians in future years. (P. 2, emphasis in original.)

The current legal framework for medical services in Canada represents an unwritten but clear bargain with Canadians.

In effect, the current legal framework for medical services in Canada represents an unwritten but clear contract with Canadians: individuals accept that their ability to access medical services privately will be restricted; in return, they can assume that they will be provided timely and appropriate medical services through a publicly funded and administered health care system. Thus, medically necessary services will be reasonably available to all on the basis of need, rather than ability to pay (Canada 2002b, 59–60).

This contract is broken if medically necessary and appropriate services are not reasonably available in a timely manner through the public system. Canadians have limited their right to use their own resources to access medical services on the understanding that public health care would make such services available, only to find that they are not there when needed. In the words of Chief Justice Dickson in *Morgentaler*, certain services are "held out to be generally available," but in reality they are practically unavailable or available only at great cost. As the Supreme Court found, any such a system is "manifestly unfair" and therefore contrary to the principles of fundamental justice (*Morgantaler* 1988, 72–73; Canada 2002b, 59–60).

This conclusion was obvious to Justice Carol Cohen in the *Stein* case, where the Court held that the purpose of the *Health Insurance Act* is to make necessary treatment available to all Quebecers in a timely fashion. It was therefore "irrational, unreasonable and contrary to the purpose of the Act" to deny access to such treatment and then deny a claim for reimbursement (1998, paragraph 32). It follows that it must equally be irrational, unreasonable, and contrary to the purpose of such legislation to require patients to access medically necessary services only through the publicly

funded health scheme and then to structure that scheme so that such services are not available on a timely basis.

Some Counterarguments

Some analysts claim that prohibiting the development of a private market for health services is necessary to maintain public support for the public health care system.

Some analysts claim that prohibiting the development of a private market for health services is necessary to maintain public support for the public health care system (see, for example, Marmor 1998, 6–8). According to this line of argument, if a private market for health care services were permitted to develop, it would cause wealthy Canadians to exit the system. Affluent individuals, who currently finance a disproportionate share of the public system, would no longer have as great a stake in the quality to services provided. Over time, the result would be erosion of public support for the public system, followed by a decline in quality.

Whether or not a loosening of the existing restrictions on the availability of private medical care would actually erode support for the public system is an empirical question that might or might not be borne out by the facts. Let us assume for the sake of discussion that this hypothesis is valid. Does it justify prohibitions on the private purchase of medical services in the face of significant delays in the availability of life-saving or medically necessary treatment? On this theory, individuals are, in effect, being asked to die or to suffer physically in order to ensure that public opinion polls continue to reflect strong support for medicare. Individual Canadians who happen to be ill and in need of medical care are thus treated as means to an end, mere objects to be sacrificed in order to advance a political agenda, rather than as ends in themselves worthy of the same concern and respect as healthy Canadians. Moreover, any strategy premised on the rationing of medically necessary treatments in order to boost public support for the health care system will almost certainly backfire. Indeed, as evidence of increasingly unacceptable delays in the availability of medically necessary services mounts, public confidence in the health care system has eroded rather than firmed (see Vail 2001, 2).

Another argument often advanced in support of the prohibition on the availability of private medical care is that loosening such prohibitions would not actually reduce overall waiting times in the public system and might even disadvantage less-affluent Canadians in terms of access to care. According to this argument, allowing for a parallel but private system would see the most competent physicians and the most affluent patients exiting the public system and availing themselves of the private alternative, leaving fewer resources available to nonaffluent patients (see Marmor 1998). A related claim is that it would be unfair to permit an affluent Canadian to access medically necessary care when his or her economically disadvantaged neighbor is unable to pay for such services (ibid.).

These counterarguments cannot withstand serious scrutiny where the public system fails to provide timely access to necessary care. First, as the Stein (1999) case illustrates, the fact that medically necessary services are not available in Canada does not mean that affluent Canadians are unable to access such services. It means simply that they must do so in another country.

Second, it cannot be open to government, in any event, to prohibit one person from utilizing his or her own resources to purchase services that are necessary to his or her health on the grounds that someone else cannot afford to purchase the

same service *and then refuse to provide the needed service to both persons*. That course would truly represent equality with a vengeance, a desire to enforce an equal outcome even if the perverse result is to deny everyone concerned timely access to needed medical care. In essence, it would treat individuals as mere objects or means to the achievement of a political ideology, without regard to the consequences for actual human beings.

People cannot be condemned to die on the grounds that allowing them to live would not also save the life of some other person.

Finally, the hypothesis that waiting lists for medically necessary services might not be reduced by permitting the private purchase of medically necessary services, even if true,[39] cannot justify prohibiting someone from accessing services that will save *that person's* life. People cannot be condemned to die on the grounds that allowing them to live would not also save the life of some other person.

Conclusion on Fundamental Justice

The Quebec Superior Court in *Chaoulli* (2000) recently came to a different conclusion, rejecting an argument that restrictions on the right to purchase insurance for medically necessary services were contrary to the principles of fundamental justice.[40] The plaintiffs in that case were not, however, able to establish that they had been denied access to timely or appropriate medical services. Their claim was that they might be denied access to such services in the future and that they ought to be permitted to purchase insurance now to guard against that eventuality.[41] The court rejected the claim, finding that the potential risk to the plaintiffs had to be weighed against the risk to the public from permitting the purchase of private health insurance. The court found that permitting private insurance coverage would threaten the integrity and proper functioning of the public health care system; it was therefore, consistent with the principles of fundamental justice to require the plaintiffs to purchase medically necessary services exclusively from the public system.

As we have already acknowledged, the constitutionally protected rights of liberty or security of the person are violated only in circumstances where an individual is denied access to timely and appropriate medical care. Having found no such denial in *Chaoulli*, the trial judge could dismiss the section 7 claim.

But *Chaoulli* does not preclude a constitutional claim based on a different set of facts and circumstances. In particular, it does not address a situation in which an individual has been denied access to timely and appropriate health care services in the publicly funded system. For an individual in this circumstance, the prohibition

39 Again, this question is empirical and may or may not turn out to be true in actual experience. However, as in the previous discussion, we assume here that the claims of the defenders of the status quo are true.

40 This case is presently under appeal to the Quebec Court of Appeal.

41 The plaintiffs were Dr. Jacques Chaoulli, a medical practitioner, and Georges Zeliotis, who was, at the time of the action, a 67-year-old unemployed man suffering from depression, a heart condition, problems with his hips, an injured shoulder (resulting from a fall), and a hernia. The court found as a fact that Zeliotis's indecision and his seeking a second opinion prior to undertaking his first orthopedic surgery, as well as the fact that his own doctor thought him less than an ideal candidate for such an operation, were the causes of the delays in his medical treatment, rather than any delays imposed by the health care system. Dr. Chaoulli was not ill. His plea to the court was that, as a citizen, he wanted to be able to take out private insurance so as to be in a position to pay an opted-out physician in the event he became ill.

on the private purchase of medically necessary services deprives him or her of security of person, liberty and perhaps even life. This outcome is precisely the opposite of what governments promised in return for requiring individuals to forgo purchasing health care services privately. If governments fail to make good on the promise upon which the health care system was constructed, the only result consistent with principles of fundamental justice is to permit individuals to take whatever steps they regard as necessary to protect their life and health.[42]

Section 1 of the Charter

Under the Charter, a finding that a law or a government action violates a substantive right does not necessarily lead to the conclusion that the law or action is unconstitutional. Section 1 requires the further step of determining whether the violation of a protected right is a "reasonable limit" that can be demonstrably justified in a free and democratic society. This section recognizes that certain rights are not absolute and may be limited in the pursuit of other legislative goals. At the section-1 stage, however, the burden of proof shifts from the claimant to the government.

Section 1 recognizes that certain rights are not absolute and may be limited in the pursuit of other legislative goals.

The framework for analysis under section 1 was established by Chief Justice Dickson's unanimous judgment, in *R v Oakes*. The government must satisfy two criteria on a preponderance of probability. First, the impugned law must pursue an objective that is sufficiently important to justify limiting a Charter right. This matter requires the identification of the objective the legislature sought in enacting the law, which is often revealed by the law itself.

Once a sufficiently important objective is identified, the government must demonstrate that the means chosen to attain it are reasonable and demonstrably justified. This criterion involves a three-part proportionality test to balance the interests of society with those of individuals and groups. First, the impugned law must be rationally connected to legislature's objective; it cannot be "arbitrary, unfair, or based on irrational considerations" (*Oakes*, 1986, 139). Second, the law must impair the right no more than is necessary to accomplish the objective. In other words, it must pursue the objective by the least drastic means. Third, the law must not have a disproportionately severe effect on the people whom it affects; as Chief Justice Lamer put the requirement in *Dagenais v CBC* (1994, 889), there must be some "proportionality between the deleterious and the salutary effects of the measures."

Theoretically, section 1 could be used to uphold statutes found to violate section 7, but a majority of the Supreme Court has never done so.[43] The reason is

42 Professor Jackman, who considered the question of a constitutional claim based on section 7 a number of years ago, came to a different conclusion. However, her analysis was premised on the assumption that medically necessary services were then available on a timely basis through the publicly funded system. As she put it, *"particularly in light of the accessibility and comprehensiveness of the current public system*, it is unlikely that a right to health care would be read so expansively as to entitle an individual to demand unlimited freedom of access to services or to choice of providers, free from any restrictions" (1995, 57, emphasis added). In effect, this analysis implicitly recognizes that the absence of such accessibility puts the constitutionality of the current restrictions on private purchase of medical services into serious doubt.

43 As Justice Lamer stated in *Reference re BC Motor Vehicle Act* ([1985), 518, *in obiter*, violations of section 7 could be upheld under section 1 "but only in cases arising out of exceptional conditions,...

that a law violating the principles of fundamental justice would not likely be reasonable or demonstrably justified in a free and democratic society. In essence, the balancing of interests prescribed by section 1 is inherent in determining whether a deprivation of a protected interest is consistent with the principles of fundamental justice component of section 7. Thus, to the extent that a deprivation of a protected interest is found to be inconsistent with the principles of fundamental justice, it could not (save in the most exceptional circumstances) be demonstrably justified in a free and democratic society.[44]

We believe that this result would obtain in relation to a claim brought against the current restrictions on access to private medical services. Assuming that a court were prepared to conclude that those restrictions violate section 7, on the grounds that Canadians are not being provided timely access to appropriate and effective health care services in the public system, that denial could not be upheld under section 1. Canadians would have agreed to give up their right to access private medical services on the assumption that the public system will provide such services, only to find that they are not available in a timely or appropriate manner. In our view, there are no exceptional circumstances that should justify such a denial of rights. Instead, governments would be required either to provide timely and appropriate access to medical care in the public system or to permit individuals to obtain medical care with their own resources. To require individuals to access medical care exclusively through an inadequate public system when they have the resources to do so privately is to condemn them to physical and psychological pain, suffering, and even death. It is not apparent how any such requirement could satisfy the standard of demonstrable justification under section 1. This conclusion is reinforced by the fact that the restrictions now in place in Canada on access to private medical care are significantly more onerous than those in place in other free and democratic societies (see, for example, Flood 2000, 284–285).

The restrictions now in place in Canada on access to private medical care are significantly more onerous than those in place in other free and democratic societies.

Conclusion: Mounting a Constitutional Challenge

We have outlined the reasoning that leads us to conclude that the current legal regime governing the delivery of health care services in Canada is vulnerable to a constitutional challenge. Our argument is that the Charter of Rights and Freedoms guarantees Canadians that if the state wishes to create a public monopoly for the delivery of health care services, it must ensure that the public system delivers those services in a timely fashion. The failure to ensure timely access to medically necessary services means that the present prohibitions and restrictions on the private purchase of these services are legally unenforceable. Moreover, it would be constitutionally improper for the federal government to attempt to use the *Canada Health Act* to penalize provinces for failing to enforce such prohibitions.

Note 43 - cont'd.

...such as natural disasters, the outbreak of war, epidemics, and the like." A minority of the Supreme Court upheld a violation of section 7 in *R v Penno* (1990, Justice Lamer concurring) and *R v Hess* (1990, Justice McLachlin).

44 In *New Brunswick v G(J)*, Chief Justice Lamer, writing for the majority, remarked that it is necessary to engage in a section-1 analysis in cases where there is a violation of section 7. However, he also noted that "section 7 violations are not easily saved by s. 1" (1999, 92).

The practical implications of our analysis can be illustrated by considering the three basic options for the future of the health care system, as outlined recently by the Kirby-LeBreton Committee (Canada 2002b, 11–12). The committee argues that Canadians can (i) continue to ration publicly funded health services, which inevitably means that waiting lists will continue to lengthen; (ii) increase taxes or other sources of government revenue in order to reduce the rationing of services and shorten waiting lists; or (iii) make some services available to those who can afford to pay for them by allowing a parallel privately funded tier of health services. Our argument is that only the second and third of these options is consistent with the requirements of the Constitution. The first option — continued rationing of health care, combined with an effective prohibition on private access to medically necessary services — involves the violation of constitutionally protected rights of Canadians and should no longer be regarded as legally viable.

What are left to examine are the practical obstacles — and they are considerable — that stand in the way of actually mounting such a challenge. The most obvious such obstacles are money and time. Only individuals who are denied timely access to medically necessary care have grounds for a constitutional complaint. But such people may not have the material resources or the time necessary to mount such a challenge effectively. Their money and energy are likely to be devoted to the task of obtaining necessary medical care, rather than filing statements of claim seeking a constitutional declaration. Moreover, a patient facing imminent peril to his or her life or health is unlikely to be in a position to tolerate the lengthy delays associated with a long trial, let alone two further levels of appeal.[45]

A potential solution is for a court to grant discretionary public interest standing to a plaintiff who would be granted the right to make constitutional arguments on behalf of patients facing undue delay in obtaining medically necessary care. Courts have indicated their willingness to grant standing on this basis in cases where there is no other reasonable and effective manner in which a constitutional question can be brought before the courts. Such a public interest plaintiff would be permitted to marshal and present evidence on behalf of individuals who have been denied access to timely medical care.

A public interest plaintiff would be permitted to marshal and present evidence on behalf of individuals who have been denied access to timely medical care.

The difficulty with proceeding in this manner is that the court hearing the matter would be deprived of the opportunity to observe first-hand the real effect the current system has on actual patients. Thus, the danger is that the court would reach a result similar to that in *Chaoulli*, with arguments relating to the costs and burdens associated with waiting for essential medical care appearing more theoretical than real. If a court is to take the courageous step of holding that the current public health care system violates the rights of Canadians, we believe it would do so only when confronted with a live plaintiff or series of plaintiffs.

A way of overcoming the practical obstacles of time and money is for a party or institution with the necessary financial resources to actively promote and fund litigation brought by ordinary Canadian patients. Such an interested party could go so far as to advertise its willingness to finance litigation on behalf of plaintiffs who were experiencing delays in the system but were not in a position to commence

45 For example, the *Chaoulli* case consumed 27 days at trial. The trial decision was rendered on February 25, 2000; more than two years later, the matter remains before the Quebec Court of Appeal.

legal proceedings. Even in the unfortunate eventuality that such plaintiffs died before the litigation could make its way to the Supreme Court of Canada, an appellate court would have discretion to permit the matter to proceed to a final resolution.

The object of such a challenge would not be to substitute judges for politicians as the primary architects of Canada's health care system. Clearly, that responsibility must remain with elected governments and their advisers. What courts and judges can do, however, is to test whether the framework politicians and governments have devised complies with minimum guarantees of fairness and rationality. The courts thus represent what Ronald Dworkin (1985) calls a forum of principle, in which limits on fundamental human rights must be demonstrably justified in accordance with political principle, rather than on grounds of expediency or convenience. We envisage a court's being asked to issue a declaration that the rights of particular plaintiffs have been violated by the legal structure that now governs the delivery of health care services in Canada. But the judiciary need not be drawn into determining how governments must respond to the constitutional difficulty we identify by, for example, mandating a waiting time guarantee, as recommended by the Kirby-LeBreton Committee (Canada 2002b, 58). Rather, elected and accountable politicians would continue to determine health care budgets and priorities and whether the current restrictions on private purchase of medically necessary services should be refashioned.

For too long, meaningful debate over reform to the Canada Health Act *and its associated regimes in the provinces has been regarded as off limits and even politically incorrect.*

For too long, meaningful debate over reform to the *Canada Health Act* and its associated regimes in the provinces has been regarded as off limits and even politically incorrect. Yet, as the Romanow Commission (Canada 2002a, 3) observes, no statute should be immune from review and rethinking. Increasingly, Canadians and their governments are recognizing that it is time to revisit and seriously debate the foundations of the public health care system.

Perhaps second only to medicare, Canadians cherish their Charter of Rights and Freedoms. We believe that the deterioration of the public health care system in this country has now reached the point at which these two valued institutions are in direct conflict with each other. We know not how this conflict will be resolved ultimately, but we are confident that the existence of such conflict means that the status quo is no longer an option.

References

Alberta. 2001. *A Framework for Reform: Report of the Alberta Premier's Advisory Council on Health.* Edmonton. The chair was Don Mazankowski.

Arnold, Tom. 2001a. "Canadian v. U.S. care: A life or death decision." *National Post*, February 6, p. A12.

———. 2001b. "Health care in Canada — It's more than just funding," *National Post*, February 2, p. A13.

Canada. 2001a. Parliament. Senate. Standing Committee on Social Affairs, Science and Technology. *The Health of Canadians — The Federal Role.* Vol. 4, *Issues and Options.* Ottawa.

———. 2001b. Parliament, Senate. Standing Committee on Social Affairs, Science and Technology. *Minutes of Proceedings.* 37th Parliament, 1st Session, Issue No. 18 (June 6).

———. 2002a. Commission on the Future of Health Care in Canada. *Shape the Future of Health Care in Canada: Interim Report.* Ottawa. Former Saskatchewan Premier Roy Romanow heads the commission.

———. 2002b. Parliament. Senate. Standing Committee on Social Affairs, Science and Technology. *The Health of Canadians — The Federal Role.* Vol. 5, *Principles and Recommendations for Reform — Part I.* Ottawa.

Canadian Bar Association. 1994. Task Force on Health Care. *What's Law Got to Do with It? Health Care Reform in Canada.* Ottawa: Canadian Bar Association.

Canadian Institute for Health Information (CIHI). 2001. *Health Care in Canada 2001.* Toronto: CIHI.

Donaldson, Cam, Craig Mitton, and Gillian Currie. 2002. "Managing Medicare: The Prerequisite to Spending or Reform." *C.D. Howe Institute Commentary* 157. Toronto: C.D. Howe Institute. January.

Dworkin, R.M. 1985. *A Matter of Principle.* Cambridge, Mass.: Harvard University Press.

First Ministers. 2000. "Communiqué on Health." Available from the Canadian Intergovernmental Conference Secretariat, Internet website: www.scies.gc.ca/cinfoab/800038004.

Flood, Colleen. 2000. *International Health Care Reform: A Legal, Economic and Political Analysis.* New York: Routledge.

———, and Tom Archibald. 2002. "Legal Constraints on Private-Financed Health Care in Canada: A Review of the Ten Provinces." University of Toronto, Faculty of Law. Mimeographed.

———, and Tracey Epps. 2001. "Can a Patients' Bill of Rights Address Concerns about Waiting Lists?" Draft Working Paper, Health Law Group, University of Toronto. October 9.

Jackman, Martha. 1988. "The Protection of Welfare Rights under the *Charter*." *Ottawa Law Review* 20: 257–338.

———. 1995. "The Regulation of Private Health Care under the *Canada Health Act* and the *Canadian Charter*."*Constitutional Forum* 6: 54–60.

Johnstone, Ian. 1988. "Section 7 of the *Charter* and Constitutionally Protected Welfare." *University of Toronto Faculty of Law Review* 46 (1): 1–47.

Karr, Andrea L. 2000. "Section 7 of the *Charter*: Remedy for Canada's Health-Care Crisis?" *The Advocate* 58: 363–374 (Part I) and 531–541 (Part II).

Kirkey, Sharon. 2002. "Ontario must pay patient's bill for cancer treatment overseas." *National Post*, March 20, p. A9.

McCarthy, Shawn. 2002. "Harris backs health-care airlifts." *Globe and Mail* (Toronto), February 21, p. A14.

McDonald, Paul, et al. 1998. *Waiting Lists and Waiting Times for Health Care in Canada: More Management? More Money? Summary Report.* Ottawa: National Health Research and Development Program.

Marmor, Theodore. 1998. "Expert Witness Report." Document prepared for the Attorney General of Quebec in *Chaoulli* (q.v. below). November.

Mazankowski Report. *See* Alberta. 2001.

Mill, J.S. [1859] 1978. *On Liberty.* Elizabeth Rapaport, ed. Indianapolis: Hackett Publishing.

Morton, F. L., and Rainer Knopff. 2000. *The Charter Revolution and the Court Party.* Peterborough, Ont: Broadview Press.

Priest, Lisa. 2002a. "Ontario's border babies stir health-care storm"; "Border babies: A list that keeps growing"; and "Border babies: Government, public await cost of care." *Globe and Mail* (Toronto), February 20, pp. A1, A4, and A5.

———. 2002b. "Troubled Ontario hospitals send high-risk births to U.S." *Globe and Mail* (Toronto), February 19, p. A1.

Quebec. 2000. Commission d'étudie sur les services de santé et les services sociaux. *Emerging Solutions: Report and Recommendations.* Quebec: Government of Quebec. The chair was Michel Clair.

Robson, William B.P. 2001. "Will the Baby Boomers Bust the Health Budget? Demographic Change and Health Care Financing Reform." *C.D. Howe Institute Commentary* 148. Toronto: C.D. Howe Institute. February.

Roach, Kent. 2001. *The Supreme Court on Trial: Judicial Activism or Democratic Dialogue?* Toronto: Irwin Law.

Romanow Commission. *See* Canada. 2002a.

Saskatchewan. 2001. Commission on Health Care. *Caring for Medicare: Sustaining a Quality System.* Regina: Government of Saskatchewan. The chair was Kenneth J. Fykes.

Simunovic, Marko, et al. 2001. "A Snapshot of Waiting Times for Cancer Surgery Provided by Surgeons Affiliated with Regional Cancer Centres in Ontario." *Canadian Medical Association Journal* 165 (4): 421–425.

Statistics Canada. 2002. "Changes in Unmet Health Care Needs." *The Daily*, March 13.

The Strategic Counsel. 2002. *A Public Dialogue on Health Care: A Report to the Ministry of Health and Long-Term Care*. Toronto: The Strategic Council.

Talaga, Tanya. 2000. "Cancer patients must wait 7 months — Delays increase for those who can't get breast radiation treatment in US." *Toronto Star*, September 12, p. 1.

Vail, Stephen. 2001. *Canadians' Values and Attitudes on Canada's Health Care System: A Synthesis of Survey Results*. Ottawa: Conference Board of Canada.

Walker, Michael, with Greg Wilson. 2001. *Waiting Your Turn: Hospital Waiting Lists in Canada*, 11th ed. Critical Issues Bulletin. Vancouver: Fraser Institute.

Court Decisions

Blencoe v British Columbia (Human Rights Commission), [2000] 2 SCR 307.

B(R) v Children's Aid Society of Metropolitan Toronto, [1995] 1 SCR 315.

Chaoulli c Québec (Procureure générale), [2000] JQ No 479 (QL).

Cunningham v Canada, [1993] 2 SCR 143.

Dagenais v Canadian Broadcasting Corporation, [1994] 3 SCR 835.

Eldridge v British Columbia, [1997] 3 SCR 624.

Godbout v Longueuil (City), [1997] 3 SCR 844.

Kramer v The General Manager, The Ontario Health Insurance Plan (Health Services Appeal and Review Board, March 11, 2002).

New Brunswick (Minister of Health and Community Services) v G(J), [1999] 3 SCR 46.

R v Hess, [1990] 2 SCR 906.

R v Morgentaler, [1988] 1 SCR, 30.

R v Oakes, [1986] 1 SCR 103.

R v Penno, [1990] 2 SCR 865.

Reference re BC Motor Vehicle Act, [1985] 2 SCR 486.

Rodriguez v British Columbia, [1993] 3 SCR 519.

Rombaut v New Brunswick (Minister of Health and Community Services) (2000), 225 NBR (2d) 298.

Stein v Québec (Régie de l'Assurance-maladie), [1999] QJ No 2724 (QL).

Stein v Québec (Régie de l'Assurance-maladie), [2000] QJ No 1241 (Que SC, March 28, 2000).

Walker v Prince Edward Island, [1995] 2 SCR 407.

Wilson v. BC Medical Services Commission (1988), 53 DLR (4th) 171 (BCCA).

The C.D. Howe Institute

The C.D. Howe Institute is a national, nonpartisan, nonprofit organization that aims to improve Canadians' standard of living by fostering sound economic and social policy.

The Institute promotes the application of independent research and analysis to major economic and social issues affecting the quality of life of Canadians in all regions of the country. It takes a global perspective by considering the impact of international factors on Canada and bringing insights from other jurisdictions to the discussion of Canadian public policy. Policy recommendations in the Institute's publications are founded on quality research conducted by leading experts and subject to rigorous peer review. The Institute communicates clearly the analysis and recommendations arising from its work to the general public, the media, academia, experts, and policymakers.

The Institute was created in 1973 by a merger of the Private Planning Association of Canada (PPAC) and the C.D. Howe Memorial Foundation. The PPAC, formed in 1958 by business and labor leaders, undertook research and educational activities on economic policy issues. The Foundation was created in 1961 to memorialize the late Rt. Hon. Clarence Decatur Howe, who served Canada as Minister of Trade and Commerce, among other elected capacities, between 1935 and 1957. The Foundation became a separate entity in 1981.

The Institute encourages participation in and support of its activities from business, organized labor, associations, the professions, and interested individuals. For further information, please contact the Institute's Development Officer.

The Chairman of the Institute is Kent Jespersen; Jack M. Mintz is President and Chief Executive Officer.

"The Health Papers" Series of *C.D. Howe Institute Commentary*

No. 163, May 2002	Aba, Shay, Wolfe D. Goodman, and Jack M. Mintz. "Funding Public Provision of Private Health: The Case for a Copayment Contribution through the Tax System." 20 pp.; $12.00; ISBN 0-88806-550-7.
No. 157, January 2002	Donaldson, Cam, Craig Mitton, and Gillian Currie. "Managing Medicare: The Prerequisite to Spending or Reform." 20 pp.; $10.00; ISBN 0-88806-540-X.
No. 151, April 2001	Donaldson, Cam, Gillian Currie, and Craig Mitton. "Integrating Canada's Dis-Integrated Health Care System." 24 pp.; $10.00; ISBN 0-88806-526-4.
No. 148, February 2001	Robson, William B.P. "Will the Baby Boomers Bust the Health Budget? Demographic Change and Health Care Financing Reform." 29 pp.; $10.00; ISBN 0-88806-523-X.